CHAPTER 50-24.1
MEDICAL ASSISTANCE FOR NEEDY PERSONS

50-24.1-00.1. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Department" means the department of health and human services.
2. "Medical assistance" means benefits paid under chapter 50-24.1 and title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].
3. "Third party" means an individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under this chapter.

50-24.1-01. Purpose.

The purpose of this chapter is to provide medical care and services to persons whose income and resources are insufficient to meet such costs, and further to provide preventive, rehabilitative, and other services to help families and individuals to retain or attain capability for independence or self-care.

50-24.1-01.1. Department to submit plans and seek waivers.

The department may submit state plans and may take such actions as are reasonably necessary to administer programs under its supervision, including the issuance of policy manuals, forms, and program directives. The department may publish dashboards that demonstrate program utilization and provider care trends. Within the limits of legislative appropriation, the department may seek appropriate waivers of the requirements of the federal statutes or regulations as authorized by federal law.

50-24.1-01.2. Department may establish and administer state unified dental insurance coverage plan.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-01.3. Department to comply with federal requirements - Interagency cooperation - Civil money penalty fund.

1. The department shall take any action necessary to comply with the requirements of section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], including establishing a process to enforce compliance by nursing facilities with requirements for participation in the medical assistance program that conforms to any federal regulations implementing that section.
2. The state treasurer shall establish a fund for the receipt of any civil money penalties imposed under subsection 1. Any civil money penalty paid to the department under subsection 1 must be deposited in that fund and, subject to the limits of legislative appropriation, may be expended for the purpose allowed by the federal government.
3. This section may not be construed to create any right or authorize any activity not provided for in section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)] or its implementing federal regulations.
4. Before the establishment and assessment of civil money penalties permitted by section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], the department is encouraged to submit a plan of alternative remedies in accordance with section 1919(h)(2)(B)(ii) of that Act.

50-24.1-01.4. Medicaid and Medicare eligible individuals.

The department may not require prior authorization, additional documentation not required by Medicare, or additional prescription requirements of durable medical equipment and supplies in order to process a claim for Medicaid-eligible individuals who are also eligible for Medicare if an item has been paid by Medicare, unless the item is not covered by Medicaid.

50-24.1-02. Eligibility.

Within the limits of legislative appropriations, medical assistance may be paid for any person who either has income and resources insufficient to meet the costs of necessary medical care and services or is eligible for or receiving financial assistance under chapter 50-09 or title XVI of the Social Security Act, as amended, and:

1. Has not at any time before or after making application for medical assistance made an assignment or transfer of property for the purpose of rendering that person eligible for assistance under this chapter. For the purposes of making any determination or redetermination of eligibility, the phrase "assignment or transfer" includes actions or failures to act which effect a renunciation or disclaimer of any interest which the applicant or recipient might otherwise assert or have asserted, or which serve to reduce the amounts which an applicant or recipient might otherwise claim from a decedent's estate, a trust or similar device, or a person obligated by law to furnish support to the applicant or recipient.
2. Has applied or agrees to apply all proceeds received or receivable by that person or that person's eligible spouse from third-party medical coverage, including health care coverage, accident insurance, and automobile insurance, to the costs of medical care for that person and that person's eligible spouse and children. The department may require from any applicant or recipient of medical assistance the assignment of any rights accruing under third-party medical coverage. Any rights or amounts so assigned must be applied against the cost of medical care paid on behalf of the recipient under this chapter. The assignment is not effective as to any carrier before the receipt of notice of assignment by such carrier.
3. Is eligible under rules and regulations established by the department.

50-24.1-02.1. Assignment of claim.

1. Each applicant or recipient of benefits under this chapter must be deemed to have assigned, to the department, any right of recovery the applicant or recipient may have for medical costs incurred under this chapter not exceeding the amount of funds expended by the department for the care and treatment of the applicant or recipient. The applicant or recipient, or other person empowered by law to act in the applicant's or recipient's behalf, shall execute and deliver an assignment of claim, assignment of rights, or other authorizations as necessary to secure fully the right of recovery of the department. The assignment:
   a. Is effective as to both current and accrued medical support recovery obligations.
   b. Takes effect upon a determination that an applicant is eligible for assistance under this chapter.
2. The department may compromise claims arising out of assignments made under this section on such terms as it may deem just and appropriate. The department may not be compelled to compromise any claim.

50-24.1-02.2. Community spouse resource allowance.

In determining eligibility for medical assistance applicants and recipients, the department shall establish a community spouse resource allowance equal to the maximum community spouse resource allowance as provided by 42 U.S.C. 1396r-5(f)(2). This section applies to a community spouse of an institutionalized spouse. For purposes of this section, "institutionalized spouse" includes an individual who is described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

50-24.1-02.3. When designated pre-need funeral service contracts, prepayments, or deposits not to be considered in eligibility determination.

1. In determining eligibility for medical assistance, the department may not consider as an available resource any pre-need funeral service contracts, prepayments, or deposits to a fund which are placed in an irrevocable itemized funeral contract designated by the applicant or recipient to pay for the applicant's or recipient's funeral.

2. An applicant or recipient designates a prepayment or deposit for that applicant's or recipient's burial by providing funds that must be used for the funeral or burial expenses of the applicant or recipient. If an applicant's or recipient's burial is funded by an insurance policy, the amount considered set-aside for burial is the lesser of the cost basis or the face value of the insurance policy. Interest or earnings retained in a funeral fund also may not be considered as an available resource.
3. A pre-need funeral service contract, prepayment, or deposit designated under this section is not a multiple-party account for purposes of chapter 30.1-31. Any amount in a pre-need funeral service contract, prepayment, or deposit designated under this section which is not used for funeral or burial expenses must be returned to the estate of the medical assistance recipient and is subject to recovery by the department from the medical assistance recipient's estate. A claim for payment of funeral expenses may not be made against the estate of a deceased medical assistance recipient except to the extent the funds are maintained in accordance with this chapter.

50-24.1-02.4. Exempt income and resources.

The department may not consider, as an available asset for purposes of determining eligibility for benefits under this chapter, income and resources set aside by a blind or disabled person as part of a plan to achieve self-support, if the plan has been approved by the social security administration.

50-24.1-02.5. Effect of purchase of insurance on disqualifying transfer.

1. An individual who secures and maintains insurance that covers the cost of substantially all necessary medical care, including necessary care in a nursing home and necessary care for an individual who qualifies for admission to a nursing home but receives care elsewhere, for at least thirty-six months after the date an asset is disposed of, may demonstrate that the asset was disposed of exclusively for a purpose other than to qualify for medical assistance by providing proof of that insurance.
2. If purchased after July 31, 2003, the insurance coverage under this section must include home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage. The coverage required under this subsection must include a daily benefit equal to at least one and fifty-seven hundredths times the average daily cost of nursing care for the year in which the policy was issued and an aggregate benefit equal to at least one thousand ninety-five times that daily benefit.
3. This section applies only to policies purchased before the effective date of an approved amendment to the state plan for medical assistance that provides for a qualified state long-term care insurance partnership under section 1917(b) of the Social Security Act [42 U.S.C. 1396p].

50-24.1-02.6. Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are medically needy persons who have countable income that does not exceed an amount determined under subsection 2.
2. The department shall establish an income level for medically needy persons at an amount no less than required by federal law.
3. The department shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.
4. The department shall provide medical assistance benefits to otherwise eligible pregnant women who are lawfully present in the United States.
5. The department may require, as a condition of eligibility, individuals eligible for Medicare part A, B, or D to apply for such coverage.

50-24.1-02.7. Workers with disabilities coverage.

The department shall establish and implement a buyin program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program:

1. Must be made available to an individual with a disability who is a member of a household with a net income less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget applicable to the household size;
2. Must allow up to an additional ten thousand dollars in assets;
3. Must require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;
4. Must include a one-time program enrollment fee of one hundred dollars;
5. Must provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program; and
6. May not require the payment of a premium or enrollment fee or disenroll an individual for failure to pay a premium or enrollment fee for workers with disabilities coverage during a federally declared emergency if collection of the premium or enrollment fee may impact the receipt of federal funds.

50-24.1-02.8. Transfers involving annuities.

1. For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two or more parties under which one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future.
2. The purchase of an annuity on or after February 8, 2006, or the selection or alteration on or after February 8, 2006, of a payment option for an annuity purchased at any time, is a disqualifying transfer of an asset for purposes of this chapter unless:
   a. The state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant or the state is named in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value;
   b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;
   c. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;
   d. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year; and
   e. The annuity will return the full principal and interest within the purchaser's life expectancy as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration.
3. Except for the provision in subdivision a of subsection 2, this section does not apply to:
   a. An annuity described in subsection b or q of section 408 of the Internal Revenue Code of 1986; or
   b. An annuity purchased with proceeds from:
      (1) An account or trust described in subsection a, c, or p of section 408 of the Internal Revenue Code of 1986;
      (2) A simplified employee pension within the meaning of subsection k of section 408 of the Internal Revenue Code of 1986; or
      (3) A Roth IRA described in section 408A of the Internal Revenue Code of 1986.

50-24.1-02.9. Effect of purchase of long-term care insurance on eligibility for medical assistance benefits.

Repealed by S.L. 2007, ch. 421, § 3.

50-24.1-02.10. Real estate taxes on rental property as deduction from rental income.

For purposes of determining the treatment of income and the application of income to the cost of care for medical assistance eligibility for an individual screened as requiring nursing care services, and who is receiving home and community-based services or nursing care services, the department shall allow as a deduction from countable gross rental income the real estate taxes for rental property if the individual is responsible for paying the real estate taxes for that property.

50-24.1-03. County share of medical assistance - Reimbursement for clinic services not required.

Repealed by S.L. 1997, ch. 403, § 13.

50-24.1-03.1. Duties of human service zone and department.

In the administration of the medical assistance program, the department or a human service zone shall investigate and record the circumstances of each applicant or recipient of assistance, in order to ascertain the facts supporting the application, or the granting of assistance, and obtain such other information as directed by the department or as may be required by the rules and regulations of the department.

50-24.1-03.2. Investigations - Power of human service zones, department, and employees.

1. In the investigation of applications under the provisions of this chapter, the human service zones, the department, and the officials and employees of such agencies charged with the administration and enforcement of this chapter may:
   a. Conduct examinations;
   b. Require the attendance of witnesses and the production of books, records, and papers; and
   c. Make application to the district court of the county to compel the attendance of witnesses and the production of books, records, and papers.
2. The department may request from other state, county, human service zones, and local agencies information deemed necessary to carry out the medical support enforcement program. All officers and employees of state, county, and local agencies shall cooperate with the department in locating absent spouses or parents of children to whom an obligation of support is owed or on whose behalf assistance is being provided and, on request, shall supply the department with available information relative to the location, income, social security number, and property holdings of the absent spouse or parent, notwithstanding any provision of law making that information confidential. Any person acting under the authority of the department who, pursuant to this subsection, obtains information from the office of the state tax commissioner, the confidentiality of which is protected by law, may not divulge such information except to the extent necessary for the administration of the medical support enforcement program or when otherwise directed by judicial order or when otherwise provided by law.
3. The officers and employees designated by the human service zones or the department may administer oaths and affirmations.

50-24.1-03.3. Criminal background investigation - Fingerprinting required.

1. When the department determines a criminal history record check is appropriate, a provider applicant, a provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider shall secure, from any agency authorized to take fingerprints, two sets of fingerprints and shall provide all

other information necessary to secure state criminal history record information and a nationwide background check under federal law.

2. The applicant provider or provider shall assure the information obtained under subsection 1 is provided to the department within thirty days of the notice date.
3. The department shall submit the information and fingerprints to the bureau of criminal investigation to determine if there is any criminal history record information regarding the applicant provider, provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider in accordance with section 12-60-24.
4. The bureau of criminal investigation shall request a nationwide background check from the federal bureau of investigation and, upon receipt of response, provide the response of the federal bureau of investigation to the department. The bureau also shall provide any criminal history record information that lawfully may be made available under chapter 12-60 to the department.
5. The results of the investigations must be forwarded to the department.
6. Upon request by the applicant provider, provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider, a law enforcement agency shall take fingerprints of individuals described in this section if the request is made for purposes of this section.
7. The applicant provider, provider, or an individual with a five percent or more direct or indirect ownership interest in the provider applicant or provider shall pay the cost of securing fingerprints, any criminal history record information made available under chapter 12-60, and a nationwide background check.
8. The department may charge a fee not to exceed the actual cost for the purpose of processing the background investigations.
9. An agency that takes fingerprints as provided under this section may charge a reasonable fee to offset the cost of the fingerprinting.
10. The department may use the background information findings to determine approval of Medicaid services provider application or termination of enrollment as a Medicaid services provider. An individual denied or terminated as a Medicaid service provider as a result of the background investigation may not be qualified to enroll as a provider, have five percent or greater ownership or control interest in a Medicaid services provider, or submit claims for reimbursement through the department's Medicaid management information system.

50-24.1-04. Authority of department.

The department may adopt rules and regulations as necessary to qualify for any federal funds available under this chapter.

50-24.1-05. Date effective.

The effective date of this chapter is the date on which federal funds become available for the purposes and program outlined herein.

50-24.1-06. Remedial eye care - When provided.

Repealed by S.L. 2021, ch. 371, § 4.

50-24.1-07. Recovery from estate of medical assistance recipient.

1. On the death of any recipient of medical assistance who was a resident of a nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution and with respect to whom the department determined that resident reasonably was not expected to be discharged from the medical institution and to return home, or who was fifty-five years of age or older when the recipient received the assistance, and on the death of the spouse of the deceased recipient, the total amount of medical assistance paid on behalf of the recipient following the institutionalization of the recipient who cannot reasonably be expected to be discharged from the medical

institution, or following the recipient's fifty-fifth birthday, as the case may be, must be allowed as a preferred claim against the decedent's estate after payment, in the following order, of:

a. Recipient liability expense applicable to the month of death for nursing home or basic care services;
b. Funeral expenses not in excess of three thousand dollars;
c. Expenses of the last illness, other than those incurred by medical assistance;
d. Expenses of administering the estate, including attorney's fees approved by the court;
e. Claims made under chapter 50-01;
f. Claims made under chapter 50-24.5;
g. Claims made under chapter 50-06.3 and on behalf of the state hospital; and
h. Claims made under subsection 4.

2. a. A claim may not be required to be paid nor may interest begin to accrue during the lifetime of the decedent's surviving spouse, if any, nor while there is a surviving child who is under the age of twenty-one years or is blind or permanently and totally disabled, but no timely filed claim may be disallowed because of the provisions of this section.
   b. The department may not file a claim against an estate to recover payments made on behalf of a recipient who was eligible for Medicaid under section 50-24.1-37 and who received coverage through a private carrier.
3. Every personal representative, upon the granting of letters of administration or testamentary shall forward to the department a copy of the petition or application commencing probate, heirship proceedings, or joint tenancy tax clearance proceedings in the respective district court, together with a list of the names of the legatees, devisees, surviving joint tenants, and heirs at law of the estate. Unless a properly filed claim of the department is paid in full, the personal representative shall provide to the department a statement of assets and disbursements in the estate.
4. A claim of the department made against the decedent's estate of a recipient of medical assistance who was a full-benefit dual-eligible recipient, or against the decedent's estate of the spouse of a deceased recipient of medical assistance who was a full-benefit dual-eligible recipient, must include a claim for an amount equal to the amount required to be paid each month under 42 U.S.C. 1396u-5(c)(1)(A), or a substantially similar federal law, which reasonably may be attributable to benefits paid on behalf of the deceased recipient in a month during which the deceased recipient received medical assistance under this chapter and was eligible for Medicare.
5. All assets in the decedent's estate of the spouse of a deceased medical assistance recipient are presumed to be assets in which that recipient had an interest at the time of the recipient's death.
6. To the extent a claim for repayment of medical assistance arises for services provided in months during which the department has in effect an approved state plan amendment that provides for the disregard of assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary of an insurance policy under a qualified state long-term care insurance partnership, the department's claim need not be paid out of assets of the decedent's estate of a recipient of medical assistance, or assets of the decedent's estate of the spouse of such a recipient, of a value equal to an amount the estate demonstrates was paid for long-term care provided to the recipient of medical assistance during those months by that insurance policy.
7. For purposes of this section:
   a. "Full-benefit dual-eligible" has the meaning provided in 42 U.S.C. 1396u-5; and
   b. "Qualified state long-term care insurance partnership" has the meaning provided in 42 U.S.C. 1396p(b).
8. In any probate proceedings in which the department has filed a claim under this section, no additional evidence of foundation may be required for the admission of the department's payment record supporting the department's claim if the payment record

is certified as a true copy and bears the signature of a representative of the department. There is a rebuttable presumption that the amount of medical assistance on the claim was incurred and paid on behalf of the recipient of medical assistance and is an allowable claim.

50-24.1-08. Statute of limitations does not run.

The statute of limitations does not run against claims of the state of North Dakota for repayment of medical assistance provided under this chapter.

50-24.1-09. Reimbursement of long-term care facility - Limitation - Allowable costs.

Repealed by S.L. 1987, ch. 582, § 30.

50-24.1-10. Joint Medicaid payment account - Educationally related services.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-11. Joint Medicaid payment account - North Dakota vision services - school for the blind.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-12. Medical assistance - Services provided by psychologists.

Within the limits of legislative appropriations, the department shall provide medical assistance to eligible recipients for services provided by psychologists licensed under chapter 43-32.

50-24.1-13. Provider reimbursement rates.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-14. Responsibility for expenditures.

Notwithstanding section 50-24.1-34, expenditures required under this chapter are the responsibility of the federal government or the state of North Dakota.

50-24.1-15. Prehospital emergency medical services.

Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist.

50-24.1-16. Reimbursement of ambulance services.

1. Medical assistance coverage must include reimbursement of ambulance services for responding to calls to assist covered individuals which do not result in transport.
2. For purposes of classifying ambulance services under this section:
   a. An emergency response is one that at the time the ambulance is called the ambulance responds immediately. An immediate response is one in which the ambulance begins as quickly as possible to take the steps necessary to respond to the call.
   b. An advanced life support assessment is an assessment performed by an advanced life support crew as part of an emergency response that was necessary because the patient's reported condition at the time of the dispatch was such that only an advanced life support crew was qualified to perform the

assessment. An advanced life support assessment does not necessarily result in a determination that the patient requires an advanced life support level of service.

50-24.1-16.1. Continuous glucose monitoring devices.

Medical assistance coverage, including Medicaid Expansion, must include coverage of a continuous glucose monitoring device for a covered individual.

50-24.1-17. Medical assistance for breast or cervical cancer.

The department may provide medical assistance for individuals screened and found to have breast or cervical cancer in accordance with the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 [Pub. L. 106-354; 114 Stat. 1381; 42 U.S.C. 1396a et seq.]. The department shall establish an income eligibility limit that may not exceed two hundred percent of the most recently revised poverty line published by the federal office of management and budget applicable to the household size.

50-24.1-18. Personal care option - Residential habilitation - Community support services.

1. The department shall implement personal care services.
2. The department may implement residential habilitation and community support services in a residential setting or private residence that would allow for the delegation of administration of medication by an employee of a qualified service provider agency. The qualified service provider agency shall employ or contract with a licensed registered nurse to provide supervision to the employees of a qualified service provider agency who are administering routine medications. The employees of a qualified service provider agency shall complete department-approved training on the administration of routine medications before administering routine medications. The department shall adopt rules as are necessary to establish and govern residential habilitation and community support services in a residential setting or private residence.

50-24.1-18.1. Consumer-directed health maintenance services - Residing at home.

Repealed by S.L. 2021, ch. 12, § 35.

50-24.1-19. Oral maxillofacial services - Medical necessity.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-20. Home and community-based living - Choice of options.

Any aged or disabled individual who is eligible for home and community-based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. To the extent permitted by any applicable waiver, the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service.

50-24.1-21. Department to submit plans and seek waivers.

Repealed by S.L. 2007, ch. 421, § 3.

50-24.1-22. Long-term care facility information.

Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-23. Long-term care facility resident - Medical assistance eligibility.

An individual is not ineligible for medical assistance if application of disqualifying transfer provisions would deprive the individual of nursing care and services and the individual makes a satisfactory showing that:

1. For periods after the return, all income or assets constituting the disqualifying transfer have been transferred or assigned back to the individual and the individual is otherwise eligible for medical assistance; or
2. Compensation equal to the fair market value of the income or asset at time of transfer is paid to, or on behalf of, the individual for nursing care and services provided by a long-term care facility and the individual is otherwise eligible for medical assistance.

50-24.1-24. Provider appeals - Definitions.

1. For purposes of this section:
   a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided or the recoupment or adjustment of a claim, or part of a claim, following an audit or review.
   b. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department or a third-party billing agency of the provider.
2. A provider may request a review of denial of payment under this section by filing a written request for review with the department within thirty days of the date of the department's denial of payment. The written request for review must include the remittance advice or the notice of recoupment or adjustment and a statement of each disputed item with the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service or for a full or partial denial, recoupment, or adjustment of a claim due to required federal or state changes, payment system defects, or improper claims submission.
3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits, and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.
4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.
5. The department shall make and issue a final decision within seventy-five days of receipt of the notice for review, if the department has denied payment for a medical assistance claim or reduced the level of service payment for a service. The department shall make and issue a decision within seventy-five days, or as soon thereafter as possible, of receipt of the notice of request for review, if the department has recouped or adjusted a claim, or part of a claim, following an audit. The department's final decision must conform to the requirements of section 28-32-39. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.
6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits, and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.

50-24.1-25. Operating costs for developmental disabilities service providers.
Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-26. Medicaid waivers - In-home services.
The department shall administer Medicaid waivers to provide in-home services to children with extraordinary medical needs and to children up to the age of eighteen diagnosed with an autism spectrum disorder who would otherwise meet institutional level of care. The department may prioritize applicants for the waiver for children with extraordinary medical needs by degree of need.

50-24.1-27. Medical assistance program management.
Repealed by S.L. 2019, ch. 408, § 39.

50-24.1-28. Medical assistance and Medicare prescription drug management program.
The department may not pay for:
1. A prescription drug that is within a class of drugs covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed to a medical assistance recipient who is also a Medicare beneficiary.
2. A prescription drug that is not covered and for which no drug in its class is covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed for an individual who is a medical assistance recipient and a Medicare beneficiary unless federal medical assistance matching funds are available at no less than the federal medical assistance percentage and the department determines that the drug is medically necessary for the individual.

50-24.1-28.1. Pharmacy management program.
The department shall establish a pharmacy management program to be used by the medical assistance program for Medicaid expansion for prescription drug coverage. The department shall process claims through the department's existing pharmacy claims system and Medicaid management information system and provide the contracted managed care plan with a daily pharmacy claims file for Medicaid expansion recipients.

50-24.1-29. Insurers to provide certain information to the department.
1. For purposes of this section:
   a. "Department" means the department of health and human services or its agent.
   b. "Health insurer" includes self-insured plans, group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that legally are responsible by statute, contract, or agreement for payment of a claim for a health care item or service.
2. a. As a condition of doing business in this state, health insurers shall provide to the department upon its request and in a manner prescribed by the department information about individuals who are eligible for medical assistance so the department may determine during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and the nature of the coverage provided by the health insurer, including the name, address, identifying number of the plan, and duration of the health insurance coverage. Notwithstanding any other provision of law, every health insurer, not more frequently than twelve times in a year, shall provide to the department upon its request information, including automated data matches conducted under the direction of the department, as necessary, to:

(1) Identify individuals covered under the insurer's health benefit plans who are also recipients of medical assistance;
(2) Determine the period during which the individual or the individual's spouse or the individual's dependents may be or may have been covered by the health benefit plan; and
(3) Determine the nature of the coverage.

b. The insurer must provide the information required in this subsection to the department at no cost if the information is in a readily available structure or format. If the department requests the information in a structure or format that is not readily available, the insurer may charge a reasonable fee for providing the information, not to exceed the actual cost of providing the information.

3. To facilitate the department in obtaining the information required by this section, a health insurer shall:
   a. Cooperate with the department to determine whether a medical assistance recipient may be covered under the insurer's health benefit plan and is eligible to receive benefits under the health benefit plan for services provided under the medical assistance program.
   b. Respond to the request for information within ninety days after receipt of written proof of loss or claim for payment for health care services provided to a recipient of medical assistance who is covered by the insurer's health benefit plan.
   c. Accept the department's right of recovery, entitlement to payment, and the assignment to the department of any right of an individual or other entity to payment from a liable third party for an item or service for which payment has been made under the state medical assistance plan.
   d. Respond to any inquiry by the department within sixty days regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the health care item or service.
   e. Agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type of format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if:
      (1) The claim is submitted by the department within the three-year period beginning on the date on which the item or service was furnished; and
      (2) Any action by the department to enforce its rights with respect to such claim is commenced within six years of the department's submission of the claim.
   f. Accept Medicaid's authorization that the item or service is covered under the state plan as if the authorization were the prior authorization made by the third party for the item or service.
   g. Agree to not deny a claim submitted by the department for failure to obtain prior authorization for an item or service.
4. A health insurer is prohibited, in enrolling an individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance.
5. The department may not use or disclose any information provided by the insurer other than as permitted or required by law. The insurer may not be held liable for the release of insurance information to the department or a department agent if the release is authorized under this section.

50-24.1-30. Third-party liability recovery.

1. The department shall seek recovery of reimbursement from a third party up to the full amount of medical assistance paid.
2. A medical assistance recipient shall inform the department of any rights the recipient has to third-party benefits and shall inform the department of the name and address of any individual, entity, or program that is or may be liable to provide third-party benefits.
3. A release or satisfaction of a cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement is not valid or effectual as against a

claim created under this chapter unless the department joins in the release or satisfaction or executes a release of its claim.

4. The department shall recover the full amount of all medical assistance provided on behalf of a recipient to the full extent of third-party benefits received by the recipient or the department for medical expenses. The department shall recover the third-party benefits directly from any third party or from the recipient or legal representative, if the recipient or legal representative has received third-party benefits, up to the amount of medical assistance provided to the recipient.
5. An applicant for or recipient of medical assistance shall cooperate in the recovery of third-party benefits.
6. To enforce its rights to third-party benefits, the department may institute, intervene in, or join any legal or administrative proceeding in its own name.
   a. If either the recipient or the department brings an action against a third party, the recipient or the department must provide to the other within thirty days after commencing the action written notice by personal delivery or registered mail of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If either the department or the recipient brings an action, the other may become a party to or may consolidate an action brought independently with the other.
   b. A judgment, award, or settlement of a claim in an action by a recipient to recover damages for injuries or other third-party benefits in which the department has an interest may not be satisfied or released without first giving the department notice and a reasonable opportunity to file and satisfy its claim or proceed with any action as otherwise permitted by law.
7. Any transfer or encumbrance of any right, title, or interest to which the department has a right with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the department for reimbursement of medical assistance provided to a recipient is void and of no effect against the claim of the department.
8. A recipient who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the department within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total medical assistance provided or to place a sum equal to the full amount of the total medical assistance provided in a trust account pending judicial or administrative determination of the department's right to the third-party benefits.
9. Notwithstanding any provision in this section to the contrary, the department is not required to seek reimbursement from, or may reduce or compromise a claim against, a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following:
   a. Actual and legal issues of liability as may exist between the recipient and the liable party;
   b. Total funds available for settlement; and
   c. An estimate of the cost to the department of pursuing its claim.

50-24.1-31. Optional medical assistance for families of children with disabilities.

1. The department shall establish and implement a buyin program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred fifty percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium for families of children with disabilities coverage during a federally declared emergency if collection of the premium may impact the receipt of federal funds.

50-24.1-32. Medical assistance - Services provided by physician assistants and advanced practice registered nurses - Primary care provider case management program.

1. The medical assistance program must recognize physician assistants and advanced practice registered nurses with the roles of nurse practitioner or certified nurse midwife as primary care providers with the same rights and responsibilities given primary care physicians under the medical assistance program. Any care provided by the physician assistant or advanced practice registered nurse with the roles of nurse practitioner or certified nurse midwife as a primary care provider under the medical assistance program must be within the scope of the physician assistant's or advanced practice registered nurse's respective license.
2. The department shall eliminate the primary care provider case management program.

50-24.1-33. Brain injury - Home and community-based services - Quality control.

1. As part of the personal care services program for eligible medical assistance recipients and as part of the department's services for eligible disabled and elderly individuals, the department shall provide home and community-based services to individuals who have a brain injury and meet the functional eligibility criteria for receipt of services.
2. The department shall conduct quality control activities and make training available to case managers and other persons providing services to individuals under this section.

50-24.1-34. Processing of claims submitted on behalf of inmates.

The department of health and human services shall process claims submitted by enrolled medical providers on behalf of inmates at county jails. Each county shall pay the department for the paid amount for the claims processed and also a processing fee for each claim submission. The department may establish a processing fee that may not exceed fifty dollars and shall update the fee annually on July first. The processing fee must be based on the actual costs to the department of the claims processing operations divided by the annual volume of claims submitted. The department shall invoice each county for payment of the processing fee.

50-24.1-35. Department to expand Medicaid coverage.

The department shall ensure Medicaid coverage includes Medicaid-covered services provided to an inmate of the department of corrections and rehabilitation or a county jail who would be eligible for Medicaid if the inmate were not incarcerated and who is admitted to an inpatient setting.

50-24.1-36. Civil sanction - Costs recoverable - Interest - Appeals.

1. For purposes of this section:
   a. "Affiliate" means a person having an overt or covert relationship each with another person in a manner that one person directly or indirectly controls or has the power to control another.
   b. "Provider" means any individual or entity furnishing Medicaid services under a provider agreement with the department.
2. A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to twenty-five percent of the amount the department was induced to pay as a result of each act of fraud or abuse. This sanction is in addition to the applicable rules established by the department.
3. A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to five thousand dollars on each act of fraud or abuse which did not induce the department to make an erroneous payment. This sanction is in addition to the applicable rules established by the department.
4. A provider, an affiliate of a provider, or any combination of provider and affiliates, that is assessed a civil sanction by the department also shall reimburse the department investigation fees, costs, and expenses for any investigation and action brought under this section.

5. Unless otherwise provided in a judgment entered against a provider or against an affiliate of the provider, overpayments and sanctions accrue interest at the legal rate beginning thirty days after the department provides written notice to the provider or the affiliate of the provider.
6. a. A provider or an affiliate of a provider who is assessed a sanction may request a review of the sanction by filing within thirty days of the date of the department's notice of sanction a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute.
   b. A provider or an affiliate of a provider may not request review under this section if the sanction imposed is termination or suspension and the notice of sanction states that the basis for the sanction is either:
      (1) The provider's or affiliate's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the Medicaid program; or
      (2) The provider or affiliate has been similarly sanctioned by the Medicare program or by another state's Medicaid program.
   c. Within thirty days after requesting a review, a provider or affiliate shall provide to the department all documents, written statements, exhibits, and other written information that supports the request for review.
   d. The department shall assign a provider's or affiliate's request for review to someone other than an individual who was involved in imposing the sanction. A provider or affiliate who has requested review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.
   e. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. The department's final decision must conform to the requirements of section 28-32-39. A provider or affiliate may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.
   f. Upon receipt of notice that the provider or affiliate has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits, and other written information submitted by the provider, affiliate, or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.
7. Determinations of medical necessity may not lead to imposition of remedies, duties, prohibitions, and sanctions under this section.
8. The remedies, duties, prohibitions, and sanctions of this section are not exclusive and are in addition to all other causes of action, remedies, penalties, and sanctions otherwise provided by law or by provider agreement.
9. The state's share of all civil sanctions, investigation fees, costs, expenses, and interest received by the department under this section must be deposited into the general fund.

50-24.1-37. Medicaid expansion - Legislative management report. (Contingent repeal - See note)

1. The department shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to

individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.
4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program.
5. Provider and managed care organization reimbursement rate information received or held by the department under this section is an open record.

50-24.1-38. Health-related services - Licensed emergency medical services personnel.

1. Medical assistance must cover services provided by community emergency medical services personnel, and other similarly licensed personnel who are licensed or certified under section 23-27-04.3, if the services are provided to an eligible recipient as defined by rule. Community emergency medical services personnel services may include health assessment, chronic disease monitoring and education, immunizations and vaccinations, laboratory specimen collection, followup care, comprehensive health and safety assessment, wound management, assess and report compliance with established care plan, medication management, and other interventions within the scope of practice for each licensure level as approved by a supervising physician, physician assistant, or advanced practice registered nurse.
2. The department shall adopt rules governing payments to licensed community emergency medical services personnel, advanced emergency medical technicians, and emergency medical technicians for health-related services provided to recipients of medical assistance, subject to necessary limitations and exclusions. A physician, a physician assistant, or an advanced practice registered nurse must supervise any care provided by a licensed community emergency medical services personnel, an advanced emergency medical technician, or an emergency medical technician.

50-24.1-39. Behavioral health services - Licensed marriage and family therapists.

Beginning January 1, 2016, the department shall allow licensed marriage and family therapists to enroll and be eligible for payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary.

50-24.1-40. Medical assistance - Tribal health care coordination agreements - Continuing appropriation - Report to legislative management.

1. As used in this section:
   a. "Care coordination agreement" means an agreement between a health care provider and tribal health care organization which will result in one hundred percent federal funding for eligible medical assistance provided to an American Indian.
   b. "Tribal health care organization" means Indian health services or a tribal entity providing health care under the federal Indian Self-Determination and Education Assistance Act of 1975 [Pub. L. 93-638; 88 Stat. 2203; 25 U.S.C. 5301 et seq.].
2. The department shall facilitate care coordination agreements. Of any federal funding received in excess of the state's regular share of federal medical assistance funding

which results from care coordination agreements, the department shall deposit eighty percent in the tribal health care coordination fund and twenty percent in the general fund.

3. There is created in the state treasury a tribal health care coordination fund.
   a. Moneys in the fund are appropriated to the department on a continuing basis for distribution to a tribal government in accordance with an agreement between the department and a tribal government. The agreement between the department and a tribal government must require the tribe to:
      (1) Use the money distributed under this section for purposes related to the ten essential services of public heath identified by the federal centers for disease control and prevention and the development or enhancement of community health representative programs or services; however, through June 30, 2025, no more than fifty percent, and thereafter, no more than thirty-five percent, may be used for capital construction.
      (2) Submit to the department annual reports detailing the use of the money distributed under this section.
      (3) Submit to the department every two years an audit report, conducted by an independent licensed certified public accountant, of the tribal government use of the money distributed under this section. A tribal government may use money distributed under this section to pay for this audit report. At the discretion of a tribal government, an audit may be conducted more often than every two years.
   b. The distribution of moneys from the fund to a tribal government must be in proportion to the federal funding received from care coordination agreement requests for services originating from within that tribal nation.
   c. At least annually, upon completion of any auditing and verification actions of the department, the department shall distribute moneys from the fund to the tribal government.
   d. If a tribal government fails to file with the department a timely annual report or audit report, the department shall withhold distribution of moneys from the fund to the tribal government until the report is filed.
   e. If an audit report or the department's review of the annual report finds a tribal government used moneys distributed from the fund for a purpose inconsistent with this section, the department shall withhold future distributions to that tribal government in an amount equal to the money used improperly. The department shall distribute money withheld from a tribal government under this subdivision if a future audit report indicates moneys distributed from the fund are used for purposes consistent with this section.
4. Before August of each even-numbered year, the department shall compile and summarize the annual reports and audit reports from the participating tribal governments data and provide the legislative management with a biennial report on the fund. Each participating tribe shall compile data and provide the legislative management with a biennial report on the tribe's use of money distributed from the fund.

50-24.1-41. Medical assistance benefits - Pregnant women - Postpartum.

The department shall seek the necessary approval from the centers for Medicare and Medicaid services to expand medical assistance coverage for pregnant women with income below one hundred seventy-five percent of the federal poverty level. Services under this section must be for the duration of the pregnancy and the postpartum period consisting of the twelve-month period beginning on the last day of the pregnancy.

50-24.1-42. Automated clearing house payments to medical assistance providers and provider applicants.

The department shall provide payment to medical assistance providers and may provide payments to provider applicants using an automated clearing house to provide for electronic

fund transfers. To receive payment, medical assistance providers and provider applicants shall provide sufficient documentation to enable the department to provide electronic funds transfers through an automated clearing house. No other forms of payment are permitted.

50-24.1-43. Medical assistance benefits - Metabolic supplements.

Medical assistance coverage must include coverage of a metabolic supplement if:

1. The metabolic supplement has been identified and agreed to be covered by the department;
2. The metabolic supplement is part of a standard recommendation for treatment;
3. A suitable metabolic supplement that is a covered outpatient drug is not available;
4. The individual is under nineteen years of age; and
5. Payment is made at a rate determined by the department.

50-24.1-44. Interpreter services.

Medical assistance coverage, including Medicaid expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section.

50-24.1-45. Medical assistance benefits - Family adaptive behavior treatment and guidance - Dental screening and assessments - Dental case management - Teledentistry.

Medical assistance coverage must include payment for the following services:

1. Family adaptive behavioral treatment and guidance to educate parents and caregivers to continue to carry out plans and recommendations of applied behavioral analysis.
2. Dental screening and assessment of patients to identify individuals in need of additional assessment, diagnostic, and treatment services.
3. Dental case management for maintenance of oral health for special populations, including elderly, special needs, medically fragile, and children.
4. Asynchronous teledentistry to reduce barriers to dental care through outreach programs and to integrate oral health into general health care settings to identify and refer treatment needs.
5. The services identified in subsections 2, 3, and 4 do not apply to Medicaid expansion.

50-24.1-46. Dual special needs plan.

By January 1, 2025, the department shall implement at least one dual special needs plan for Medicare and Medicaid dual-eligible Medicaid recipients. The department shall establish standards for care coordination services the dual special needs plan must provide to recipients.

50-24.1-47. Family caregiver service pilot project - Report. (Contingent expiration date - See note)

1. The department shall establish the family caregiver service pilot project to assist in making payments to a legally responsible individual who provides extraordinary care to an eligible individual who is a participant in the Medicaid 1915(c) waivers, excluding the home and community-based services aged and disabled waiver.
2. The family caregiver service pilot project may include funding for extraordinary care, which means care:
   a. Exceeding the range of activities a legally responsible individual would ordinarily perform in the household on behalf of an individual without extraordinary medical or behavioral needs; and
   b. Is necessary to assure the health and welfare and avoid institutionalization of the individual in need of care.
3. The department may adopt rules addressing management of the family caregiver service pilot project and establish the eligibility requirements and exclusions for the family caregiver service pilot project. The department shall utilize an assessment of an eligible individual to determine the level of care authorized and to determine the best

interests of the individual in need of care. The pilot project may not provide a payment for any care that is otherwise compensated through a Medicaid 1915(c) waiver or the Medicaid state plan.

4. A decision on an application which is issued by the department under this section may be appealed as provided under chapter 28-32. An individual may not appeal a denial, a revocation, a reduction in payment, or the termination of the family caregiver service pilot project administered by the department due to the unavailability of funding received for the purpose of issuing payments as part of the family caregiver service pilot project for the biennium.
5. The department shall provide the legislative management with periodic reports on the impact, usage, and costs associated with the family caregiver service pilot project.